

Patient ID#



Indiana Tobacco Quitline
CLINIC FAX REFERRAL FORM
FAX 1.800.483.3114

Clinic

Date Fax Sent ____/____/____

PROVIDER INFORMATION

Clinic Name _____

Health Care Provider _____

Address _____

City _____ State _____ Zip _____ County _____

I am HIPAA-Covered Entity (check one) ☐ Yes ☐ No ☐ I Don't Know

Fax (____) _____ - _____ Phone (____) _____ - _____ email _____

Comments _____

PATIENT INFORMATION

Gender ☐ Male ☐ Female **Pregnant?** ☐ Yes ☐ No

Patient Name _____ Date of Birth ____/____/____

Address _____

City _____ State _____ Zip _____ County _____

Primary Phone# (____) _____ - _____ **TYPE** ☐ Home ☐ Work ☐ Cell ☐ Other

Secondary Phone# (____) _____ - _____ **TYPE** ☐ Home ☐ Work ☐ Cell ☐ Other

Language Preference (check one) ☐ English ☐ Spanish ☐ Other _____

Tobacco Type (check all that apply) ☐ Cigarettes ☐ Smokeless Tobacco ☐ Cigar ☐ Pipe

(Initial) I am ready to quit tobacco and request the Indiana Tobacco Quitline contact me to help me with my quit plan.

(Initial) I **do not** give my permission to the Indiana Tobacco Quitline to leave a message when contacting me.

Patient Signature _____

The Indiana Tobacco Quitline will call you. Please check the BEST 3-hour time frame for them to reach you.

Note: The Quitline is open 7 days a week; call attempts over a weekend may be made at times other than the selected 3-hour time frame.

☐ 6am-9am ☐ 9am-12pm ☐ 12pm-3pm ☐ 3pm-6pm ☐ 6pm-9pm

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